FINANCIAL ASSISTANCE APPLICATION

OFFICE USE ONLY

CareNet#_____ % of Co-Pay_____ H-Cap_____ Medical Home

Charity_____ Start Date_____ End Date _____

Patient's Name_____ Applicant Name_____
(if different from patient)

Patient's SS#_____ Patient's DOB_____

Address_____ City_____ State_____ Zip_____

Phone #_____ Alternate Phone # _____

Spouse's Name_____ Spouse's DOB_____

Spouse's SS#_____

Have you been a Lucas County resident for the past 6 months? ☐ Yes ☐ No

United States Citizen? ☐ Yes ☐ No

Patient's Primary Care Physician: _____ **Clinic Name:** _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widow/widower

Gender: ☐ Male ☐ Female **If female & over 40 are you enrolled in BCCP?** ☐ Yes ☐ No

Are you a U.S. Veteran: ☐ Yes ☐ No

Do you receive VA Benefits: : ☐ Yes ☐ No

Optional:

Ethnicity: Hispanic or Latino? ☐ Yes ☐ No

Race: ☐ Alaskan Native ☐ American Indian ☐ Asian ☐ Pacific Islander ☐ Black ☐ White ☐ Other_____

Primary Language Spoken: ☐ English ☐ Spanish ☐ Other_____

Provide information for ALL people in your <u>immediate</u> family who live in your home

*If zero (0) income is reported, explain how patient is supporting self_____

*Number of people in your family:_____ If you need more space, please attach a separate sheet

Name	DOB	Relationship to patient	Adopted, Natural, Step-child	Current gross monthly income	Type of income**	Gross income 3 months prior to date of service	Gross income 12 months prior to date of service
				$		$	$
				$		$	$
				$		$	$
				$		$	$
				$		$	$

**Types of income included are: wages, self employment, social security, unemployment, child support, alimony, workers' comp., pension, VA benefits, OWF, etc.

***Provide income verification with application.** Income verification may include: pay stubs, 1040 IRS tax forms, W-2's, self employment records, award letter, bank statement, etc.

PLEASE LIST ALL CURRENT EMPLOYERS

1) **Are you currently employed?** ☐ Yes ☐ No

Patient Current Employer(s) & Phone #(s) with start date(s) : _____

_____

All Patient's Previous Employers in past 12 months (please list beginning and end dates):

_____

_____

_____

All Spouse Employer(s) in the past 12 months (please list beginning and end dates): _____

_____

2) **Have you applied for Medicaid or Disability Assistance**? ☐ Yes ☐ No……if Yes,
What where the results?_____ Billing #_____

3) **Do you have health insurance (other than Medicaid)**? ☐ Yes ☐ No…..if Yes,
List type of insurance_____ Policy #_____ Group#_____

4) **Do you now, or have you in the past, had a workman's comp claim?** ☐ Yes ☐ No If Yes,
Date_____ Claim #_____ Medical Problem_____
Are you still receiving benefits ☐ Yes ☐ No Medical Treatment_____

5) Were you an Ohio resident at the time of hospital service ☐ Yes ☐ No

6) **Please indicate if any of the outstanding medical bills with our facilities are due to a Motor Vehicle accident or due to Liability**? ☐ Yes ☐ No…..if Yes, please complete the following section:

Name of Auto Insurance_____

Insurance Address_____

Policy Number_____

Insurance Agent's Name/Phone_____

Name of person liable for accident_____

7) **Do you have assets over $10,000** such as savings, checking, home equity, stocks, bonds, 401, IRA, CD's, etc?
Yes ☐ No ☐ If Yes, list type and amount_____

I have read and understand the **Notice of Privacy Practice:** ☐ Yes ☐ No

I understand any financial assistance provided may be reversed if it is determined this information is not correct.

"Providing false information to induce another to extend credit or to bestow any other valuable benefit may be a violation of the Ohio Revised Code Section 2921.13".

By my signature below, I affirm the information on this application is true to the best of my knowledge.

_____ _____ _____ _____
Signature of patient Date Signature of spouse Date

_____ _____
Signature of enrollment coordinator Date

_____ _____
Medicaid Application Confirmation Number **Date of Medicaid Application**